5.140 Personal Comfort Items and Medical Supplies and Equipment

Alcohols (rubbing antiseptics and swabs)
Analgesic rubs (Ben-Gay, Infrarub, Vicks Vaporub, etc.)
Antiseptics (Betadine, iodine, mercurochrome, merthiolate and similar products)

Baby, comfort and foot powders
Body lotions, skin lubricants and moisturizers (olive oil, Nivea oil and cream, Lubath, Alpha-Keri, Keri Lotion, etc.)
Blood glucose testing supplies, including strips

Cotton tipped applicators and cotton balls

Deodorants
Denture products (adhesives and cleaning products)
Disposable tissues (Kleenex, etc.)
Dressings (adhesive pads, abdominal pads, gauze pads and rolls, eye pads, sanitary pads, stockinette, Opsite and related items)

Enema administration apparatus

Gloves (latex and vinyl)

Hydrogen peroxide

Lemon or glycerin swabs
Lubricating jellies (Vaseline, KY jelly, etc.)

Oral hygiene products (dental floss, toothpaste, toothbrush, Waterpik)

Phosphate enemas
Plastic or adhesive bandages (e.g. Band-aids)

Shampoos (except specialized shampoos as Selsun and similar products)
Soaps (antiseptic and non-antiseptic)
Straws (paper and plastic)
Syringes and needles, Lancets (disposable and reusable)

Tapes, all types
Tincture of benzoin
Tongue depressors
Tracheotomy care sets and suction catheters
Tube feeding sets and components part

NOTE: Although these are the most common of the personal comfort items, this is not intended to be an all-inclusive list. Exceptional supply needs subject to prior authorization are based upon the Department's guidelines pursuant to Section 4.695.

5.150 All Non-Expendable, Reusable Materials

Abdominal binder
Abdominal support
Adaptive dressing equipment
Adaptive eating utensils
Adaptive hygiene equipment
Air cleaner
Air splints
All non-expendable, reusable materials (bedpans, thermometers, Towels, linen, ace bandages, rubber pants, etc.)
Alternating pressure pumps
Apnea monitor
Aquaped (K pad)

Bath bench
Bath lifts
Bath sling
Bed, electric
Bed, hospital
Bed rails
Blood glucose monitor

Commodes
Crib, hospital-type
Crib with enclosed top
Cushions, all types, wheelchairs

Elbow protectors
Elevated toilet seats
Enuretic alarm
Exercise equipment
Exercycle (exercise bike)

Floor stand, trapeze
Floor stand, weights
Flotation pads
Food pumps
Foot boards (model)
Foot protectors

Geriatric chairs
Gait belts

Hand cones
Hand splints, soft
Hosiery, including support and thrombo-embolytic disease stockings
Hoyer or other hydraulic or non-hydraulic lift
Humidifier
IPPB (Intermittent positive pressure machine)
IV Poles

Lamp, heat and ultraviolet Lap boards/trays, wheelchair

Mat, exercise
Mattress, air, alternating pressure, gel, foam
Mattress pads
Lower extremity splints/positioners (e.g. mulitodus)

Name tags

Oxygen masks, canulas, tubing, nebulizer, flow meter

Patient lifts
Positioning equipment for wheelchairs, chairs and beds
Prone standers
Pulse oximeter

Reachers
Restraints
Roho, Jay or similar flotation cushion

Safety rails – hallways, bathroom areas (tub, toilet, shower)
Sitz baths – portable
Sliding boards
Standing tables
Suction machine (standard)

TENS units
Transfer devices
Traction apparatus
Trapeze
Tub, rail

Vaporizer, room
Volumetric pump

Walkers, canes, crutches (including quad-canes)
Water mattress
Wheelchairs, all manual
Wheelchairs, power (See Sec 5.160)
Whirlpool
Wrist bands and alarm systems

5.160 Durable Medical Equipment and Wheelchairs - Exceptions

5.162 General. Durable medical equipment and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipients without charge to the patient, the patient's family, or other interested persons. The cost of all wheelchairs, including geriatric chairs but excluding motorized wheelchairs or vehicles, is included in the nursing home payment rate.

Under certain exceptions, durable medical equipment (DME) and wheelchairs may be billed separately by the supplier if prior authorized. The prior authorization request must document the need for the item according to the exception criteria described below.

5.164 Durable Medical Equipment. Exceptions to permit separate payment for DME may be allowed by the Department if the DME is personalized or custom-made for a recipient resident and is used by the resident on an individual basis for hygienic or other reasons. These items include orthoses, prostheses (including hearing aids), orthopedic or corrective shoes, or pressure relief beds.

5.166 Special Adaptive Positioning or Electric Wheelchairs. The Department may permit separate payment for a special adaptive positioning or electric wheelchair, while a recipient resides in a nursing home, if the wheelchair is prescribed by a physician and the following criteria are met:

1. The wheelchair is personalized in nature or is custom-made for a patient and is used by the resident on an individual basis for hygienic or other reasons, AND

2. The special adaptive positioning wheelchair or electric wheelchair is justified by the diagnosis and prognosis and the occupational or vocational activities of the recipient (i.e., educational, therapeutic involvement).

Exceptions for wheelchairs may be allowed for the recipient who is about to transfer from a nursing home to an alternate and more independent setting.

5.167 References. Information regarding DME and wheelchairs is contained in HFS 107.24, Wis. Adm. Code, and in the DME Provider Handbook. (For more information on prior authorization, see HFS 107.02(3), Wis. Adm. Code.)

5.200 OVER THE COUNTER DRUGS

5.210 General. Certain over-the-counter drugs are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such over-the-counter drugs are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

The following is a partial list of items covered by Section 5.200. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

Aspirin	Vaginal products	hemorrhoidal products
Ibuprofen	Digestive aids	antibiotics
vitamins	Saliva substitutes	pediculicides
non-covered cough & cold products	Acetaminophen	decubitus treatments
non-covered ophthalmic products	Laxatives	quinine
topical steroids	Minerals	antidiarrheals
antifungals	Antihistamines	

The above list does not represent the entire list of drugs covered under Section 5.200 and other non-covered over-the-counter drugs may be added to this section. Over-the-counter drugs covered under this section must be on the Bureau's approved OTC list or index.

5.300 COST REPORT INFLATION AND DEFLATION FACTORS

Inflation and deflation factors to adjust expenses from nursing home cost reports to the common period are given below. The common period is the twelve-month period prior to the payment rate year. The factors listed below apply to annual nursing home cost reports ending in the following months.

5.310 Direct Care

	January February March 1998	April May June 1998	July August September 1998	October November December 1998
Wages	5.3%	4.0%	2.9%	1.9%
Fringe Benefits	2.0%	1.6%	1.2%	0.8%
Supplies	2.1%	1.7%	1.3%	0.9%
Purchased Services	3.3%	2.6%	2.0%	1.3%

5.320 Support Services

	January February March 1998	April May June 1998	July August September 1998	October November December 1998
Composite Support Service Expenses	3.5%	2.7%	2.0%	1.3%

5.330 Administrative and General Services

	January February March 1998	April May June 1998	July August September 1998	October November December 1998
Composite Administrative and General Services Expenses	3.5%	2.7%	2.0%	1.3%

5.340 Fuels and Utilities

	January February March 1998	April May June 1998	July August September 1998	October November December 1998
Fuel Oil	-9.7%	-7.9%	-6.2%	-4/0%
Natural Gas	-1.7%	-2.2%	-1.9%	-0.8%
LP Gas	-1.7%	-2.2%	-1.9%	-0.8%
Coal	-9.7%	-7.9%	-6.2%	-4.0%
Electricity	-3.9%	-3.0%	-2.0%	-1.9%
Water and Sewer	3.9%	2.8%	2.0%	1.4%

5.350 Over-the-Counter Drugs

Inflation rate to the common period	2.1%	1.7%	1.3%	0.9%

5.360 Alternate Cost Report Periods. The Department may establish alternate inflation or deflation factors for cost reporting periods not listed above.

5.700 PROPERTY TAX PAYMENT PARAMETERS

5.710 Real Estate Tax and Municipal Fees Increments.

Increment for facilities subject to real estate taxes = $0.13 ppd.

Increment for facilities subject to municipal fees = $0.01 ppd.

Note: For facilities subject to both, the Department will calculate a blended increment. A blended increment is simply a proration based on the real estate taxes and the municipal fees for facilities subject to both. The blended increment will be prorated based upon the net allowable nursing home expenses for property taxes and municipal service fees. In such instances, the increment is based on a ratio of the net allowable property tax amount and of the municipal fee amount with the proportionate share of each applied to the allowable increments above with the total of the allowable increments resulting in the blended increment-based allowance.

5.800 CAPITAL PAYMENT PARAMETERS

5.810 Capital Increments.

(a) ICF-MRs $3.29
(b) NFs $1.06

For distinct part facilities only, the capital increment will be a blended increment based on ICF-MR and NF patient days in the cost reporting period.

5.820 Service Factors

(a) T1 6% of equalized value (after adjustments under Sections 3.531(a) and (b)

(b) T2 7.5% of equalized value (after adjustments under Sections 3.531(a) and (b)

5.830 Equalized Value

Equalized Value: $48,800

5.840 Cost Share Value

5.840(a) Cost Share Value: 20%

5.840(b) Cost Share Value for nursing facilities referenced in Sections 3.070 and 3.532: 40%

5.850 Incentive Value

Incentive Value: 20%

5.900 OVER-THE-COUNTER DRUGS PAYMENT PARAMETERS

5.910 OTC Increase Allowance. The inflation factor to adjust payment and expense to the payment rate year shall be 2.6%.

SECTION 6.000 MEDICAID NURSING HOME PAYMENT RATE METHODS ADDENDUM FOR STATE PLAN PURPOSES

6.100 COST FINDING AND REPORTING

6.110 Provider Cost Reports. All NF and ICF-MR facilities, which are certified to participate in the Medicaid program, must complete the uniform cost report prescribed by the Department. Completed cost reports must be submitted to the Department normally no later than three months after the close of each cost reporting period. An additional 30 days may be allowed to facilities that have a certified audit completed for the period of the cost report. A copy of the audit report including certified financial statements and notes thereto must be submitted with the cost report. The cost of central administrative services generally are to be reported using the Department's home office cost allocation report, a Medicare cost allocation report, or another cost allocation report acceptable to the Department.

The cost reports, which will be based on the uniform chart of accounts approved by the Department, must be completed in accordance with generally accepted accounting principles (GAAP) and the accrual method of accounting. The Department may allow exceptions to reporting under certain specific accounting standards. Facilities under 30 beds may be exempted from accruing certain items. Governmental institutions normally operated on a cash method of accounting may use this method, if they so desire.

Also see Section 1.170 of this Methods regarding cost reporting requirements.

6.120 Cost-Finding Method. The cost-finding method used by NF and ICF-MR facilities is described in the cost report. The cost report requires basic cost and statistical information used in the calculations of the payment rates.

6.130 Actual Costs Considered. The Methods referenced in this Methods are intended to take into account the reasonable, actual costs of nursing home services and to provide rates which will be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated. This level is determined from study and analysis of cost reports submitted by facilities. Such an analysis may include the use of representative sample of facilities' cost reports.

6.200 AUDITS

6.210 General. The Department will periodically audit cost reports submitted by nursing home providers and the related financial and statistical records of the providers. The providers selected for on-site audit and the scope of the on-site audit will be determined by: (1) a desk analysis of the cost report submitted by each provider or (2) other criteria determined by the Department. On-site audits will generally be selective in scope.

6.220 Desk Analysis of Cost Reports. Upon submission of the cost reports to the Department, desk reviews will be conducted by Department auditors to determine that, to the extent possible and necessary for rate-setting: (1) only those expense items that the Department has specified as allowable costs are included in the computation of the costs of the nursing home services and (2) expenses have been reliably reported.

Based on the results of the cost report analysis, some of the submitted cost reports will be selected for further on-site examination. The audit will be limited to specific items in the cost report based on the desk analysis or other observations.

6.230 Overpayments Identified and Recovered. Overpayments identified in the audit of a nursing home provider's cost report(s) will be recovered from the provider. Immaterial amounts may not be recovered.

6.300 SEPARATELY BILLABLE ANCILLARY ITEMS

6.310 Items. The costs for the following items may be billed separately by the nursing home and, thus, are not included in the calculation of the daily payment rate of the nursing home:

a. Tracheostomy and ventilatory supplies and related equipment, subject to guidelines and limitations published by the Department;

b. Transportation provided by a nursing home to permit a recipient to obtain health treatment or care if the treatment or care is prescribed by a physician as medically necessary and is performed at a physician's office, clinic, or other recognized medical treatment center. Such transportation may be provided in the nursing home's own controlled equipment and by its staff, or by common carrier, such as bus or taxi.

c. Oxygen, as provided in cubic feet, pounds, or tanks, or the daily rental of oxygen concentrators using the HCFA 1500 claim form. (The nursing home will be subject to maximum fees for these services, and prior authorization is required for more than 30 days rental of an oxygen concentrator.)

6.320 Reimbursement Manner. The costs of services and materials identified above which are provided to patient recipients shall be reimbursed in the following manner:

a. Claims shall be submitted under the nursing home's provider number, and shall appear on the same claim form used for claiming reimbursement at the daily nursing home rate.

b. The items shall either have been prescribed in writing by the attending physician or the physician's entry in the medical records or nursing charts shall make the need for the items obvious.

c. The amounts billed shall reflect the fact that the nursing home has taken advantage of the benefits associated with quantity purchasing.

d. Reimbursement for questionable materials and services shall be decided by the Department.

e. Claims for transportation shall show the name and address of any treatment center to which the patient recipient was transported and the total number of miles to and from the treatment center.

f. The amount charged for transportation may not include the cost the facility's staff time, and shall be for an actual mileage amount.

6.400 REIMBURSEMENT OF OUT-OF-STATE NURSING HOMES

Nursing home services may be provided to a Wisconsin Medicaid recipient in a nursing home located outside the State of Wisconsin, provided the home is certified in the Medicaid program of the other state.

Payment for temporary coverage of the Wisconsin recipient at the out-of-state home will be at a standardized payment rate for the month of admission and for a maximum of three full calendar months after the admission date. The Department will establish the standardized payment rate based on the approximate average payment rate for a comparable level of care as paid to Wisconsin nursing homes in the July preceding the admission date.

A payment rate more specific to the out-of-state nursing home may be established if: (1) the temporary coverage payment rate is not appropriate for the patient; (2) the temporary rate is not appropriate for the nursing home; (3) the facility requests a specific payment rate; or (4) the period of the temporary payment rate has been completed.

In determining a different rate, the Department may take into consideration: Medicaid rates which are being paid to the facility by states other than Wisconsin; payment for similar services in Wisconsin; available information on the cost of the facility's operation; and any specialized services or unique treatment regimens which may not be available in Wisconsin at a similar or lesser cost.

Ancillary items listed in Section 3.800 may be separately reimbursed to the out-of-state nursing home, if coverage for such materials or services is not included in the daily care rate.

COMPARISON OF OBRA '87 AND OBRA '90 WITH WISCONSIN NURSING HOME REQUIREMENTS
(CH. HFS WIS. ADMIN. CODE)

1. Nurse Staffing

State regulations under HFS 132.62(2) and (3), Wis. Adm. Code, comply with OBRA '87 requirements in all areas.

2. Other Staffing

Requirements in this area with the exception of social worker staffing, are met by State regulations under HFS 132.63 (dietary services), .64 (rehabilitative services), .65 (pharmaceutical services), .66 (laboratory, radiologic and blood services), .67 (dental services), and .69 (activities), Wis. Adm. Code. Medical records requirements are fulfilled under HFS 132.45, Wis. Adm. Code. Currently, Wisconsin requires either a full-time or part-time social worker (HFS 132.68(2), Wis. Adm. Code), while OBRA mandates at least a full-time social worker for facilities over 120 beds.

3. Continuing Education for Nurse Aides

HFS 129, Wis. Adm. Code, effective July 1, 1991, complies with all OBRA requirements.

4. Resident Assessment

Current State requirements at HFS 132.52(3) through (6), Wis. Adm. Code, require evaluation and assessment at the time of admission to the facility. A minimum data set and resident assessment protocols are required along with a quarterly review and annual reassessment. The State has specified the HCFA MDS as the resident assessment instrument for all nursing homes in the State to use.

5. Plans of Care

The initial Plan of Care (HFS 132.52(4), Wis. Adm. Code) is required under state code upon admission to a facility and, within 4 weeks of admission, a care plan must be written. The care plan must be reviewed, evaluated, and updated as necessary (HFS 132.60(8), Wis. Adm. Code). Required areas/contents of the care plan correspond to OBRA '87 requirements. While timing of the comprehensive plan differs from OBRA '87, other requirements, in general, comply.

6. Resident Personal Funds

State regulation under HFS 132.31, Wis. Adm. Code, requires all resident funds be deposited in an interest-bearing account with separate accounting for each resident. A quarterly report must be made to each resident except in cases of discretionary expenditure authority for the facility, in which case, reporting may be monthly. To comply with OBRA '87, facilities will have to establish a second, non-interest bearing account or petty cash fund for amounts under $50 and re-adjust for current interest-bearing monies under $50. Further, facilities must notify resident when his/her account reaches $200 less than the MA eligibility limits. Monitoring compliance with these requirements performed by the state survey agency and the state Medicaid agency is based on an interagency agreement.

7. Resident Rights

All State requirements for facilities meet the OBRA requirements regarding all residents rights issues. However, the State continues to work with facilities to reduce both physical and chemical restraint use in nursing facilities.

8. Compliance with the Definition of a Nursing Facility

All facilities are in compliance with the OBRA definition of a nursing facility or operating under a waiver of specific portions of the regulations.

ANALYSIS AND SUMMARY FOR OBRA '87 AND '90

Wisconsin has reviewed its estimates for the cost of implementing the requirements of OBRA '87 and OBRA '90. The following represents the cost analysis and summary of OBRA implementation for the payment rate year.

Several sources were used to estimate costs of OBRA '87. Primarily these are the survey guidelines issued by HCFA reviewed against costs itemized on nursing facility cost reports, two clinical resident surveys conducted in a group of Wisconsin's nursing facilities, and an analysis of facility staffing collected during annual facility surveys. For both the resident assessment system and freedom from restraint requirement, resident sampling was conducted to estimate additional staff time needed to conduct the activities necessary to comply with the new requirements. This information is updated with survey information as it becomes available and cost report information that document staffing in NFs and ICF-MRs. We believe that facilities completed implementation of OBRA on or before October 1, 1990, as required by federal law. The cost reports for rate setting are from facility fiscal years subsequent to 1990; therefore, the cost of implementing the requirements of OBRA '87 and OBRA '90 are now totally incorporated into the cost reports that are used for the payment plan.

1. Nurse Staffing: For the facilities licensed and certified as SNF (NF) prior to implementation of OBRA '87, it is determined that no additional costs are being incurred since current state regulations already comply with OBRA '87 requirements in this area. (See Comparison on Current Wisconsin and OBRA '87 Requirements.)

2. Plans of Care: It is anticipated that no additional costs are being incurred to comply with the Plan of Care Requirements. (See Comparison of Current Wisconsin and OBRA '87 Requirements.)

3. Resident Assessments: The agency, in a joint effort with the nursing home industry, conducted a sample survey of residents in ten nursing facilities to determine the additional time necessary to fulfill the requirements to complete the new MDS and RAP. An average of 2.63 additional nursing hours were needed, an average 1.13 social work hours and an average 0.74 activity hours were reported. Based on the average salary and fringe benefit costs from 1988 cost reports, inflated to the 1990-91 year, the estimated implementation cost was $2.0 million. It is assumed that the total cost of implementation has been reported on facility cost reports that will be used for establishing rates.

4. Other Staffing: Survey results indicate no additional needs beyond the funding made available during the 1990-91 rate year.

5. Continuing Education for Nurses Aides: Based on revised regulations, continuing education requirements for nurses aides have been significantly reduced over original OBRA estimates. No additional funding is required.

6. Resident Rights: Implementation of this requirement was completed during previous cost report periods.

7. Resident Personal Funds: Implementation of these requirements indicate no additional funding will be necessary for the payment rate year.

8. Compliance with the Definition of "Nursing Facility":

   A. Physical Plant Requirements. Review of the new Federal Survey Guidelines indicated that major renovations may be necessary for a number of facilities to bring their heating, ventilation and air conditioning (HVAC) systems up to compliance with OBRA '87 temperature requirements. To estimate costs, 18 previous projects were identified and the average cost of these projects was used as the cost of new projects. In addition, it is anticipated that some facilities will have to construct additional spaces for activities, therapies and other ancillary services. The cost basis for these construction projects to "ancillary areas" is estimated at the equivalent of 50% of the construction of new bed areas.

   Total necessary HVAC renovation and ancillary space additions are expected to cost $3.2 million in prior rate years. We believe that all facilities are now in compliance with the definition of a nursing facility and costs have been incorporated into the cost reports.

   B. ICF Conversion. The basis for this estimate is the change in rates for 11 facilities converting from ICF to SNF licensure since July 1, 1987, inflated forward. The average change was applied to patient days for the remaining 14 ICF facilities at an estimated cost of $1.092 million. All conversions have been completed prior to this rate period; therefore, their conversion costs are included in the cost reports that will be used to establish rates for this reimbursement period.

9. Services Required to Ensure the Highest Physical, Mental and Psychosocial Well-Being of Each Resident: The costs of this requirement are included in the resident direct care costs estimated in items 1-6. The objective of requirements included in these items is the maximization of physical, mental and psychosocial well-being of all residents.

DOH/BHCF Version 1.0

WISCONSIN MEDICAID NURSING FACILITIES
PAYMENT RATE WORKSHEET
--- For JULY 1998 to JUNE 1999 ---

FACILITY: _____ POP-ID: _____

CITY: _____ DATE: _____

PREPARED BY: _____ EFFECTIVE DATE: _____

Facility's Cost Reporting Period Begins _____ Ends _____ Calendar Days in Cost Report: _____

	Rate Calculation per Section 7.000 of Methods			DD3	DD2	DD1B	DD1A	ICF 3 & 4	ICF-2	ICF 1	SNF	ISN
1	Base Rates	From 6/30/98 w/s, Pg. 12, Ln. 19		$	$	$	$	$	$	$	$	$
	Less Items Not Subject to Increase:											
2	Property Allowance	From 6/30/98 w/s, Prop. Pg. 2, Ln. 23		( )	( )	( )	( )	( )	( )	( )	( )	( )
3	Ancillary Add-On	From 6/30/98 w/s, Pg. 1, Ln. 11		( )	( )	( )	( )	( )	( )	( )	( )	( )
4	Energy Saving Incentive	From 6/30/98 w/s, Pg. 9, Ln. 25		( )	( )	( )	( )	( )	( )	( )	( )	( )
5	Base Rates Subject to Increase	Lines 1 to 4		$	$	$	$	$	$	$	$	$
	Rate Increases:											
6	Percentage Increase	Section 7.211 of Methods	1.70%									
7	Percentage Increase Amount	Line 5 x Line 6										
8	Fixed Increment by Level	Section 7.211 of Methods		1.510	1.920	2.230	2.230	0.780	0.960	1.190	1.450	1.720
9	Base Rates Including Increases	Lines 5 + 7 + 8		$	$	$	$	$	$	$	$	$
	Plus Items Recalculated from Current Cost Report:											
10	Property Allowance	From Prop. Pg. 2, Ln 23										
11	Ancillary Add-On	From Auditor's Worksheets										
	Energy Saving Incentive (Section 3.320 of Methods):											
12	Approv. Energy Saving Exp.	From Auditor	$ _____									
13	Incentive Percent	Section 3.320 of Methods	25.0%									
14	Gross Energy Savings Incentive	Line 12 x Line 13	$ _____									
15	Patient Days (Min. Occupancy)	From Page 2, Line 13										
16	Calendar Days in Cost Rpt.	From Above										
17	Adjustment Multiplier	365 ÷ Ln 16 (If 366, use 1.0000)										
18	Annualized Patient Days	Line 15 x Line 17										
19	Energy Savings Incentive	Line 14 ÷ Line 18	$ _____									
20	**RATES FOR APPROVAL**	Lines 9 + 10 + 11 + 19		$	$	$	$	$	$	$	$	$

TN #98-011
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 DEC 18 1998
Approval Date _____

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